STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155356	A. BUILDING 01 B. WING	04/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL CARE UNIT OF ST JOSEPH	700 BROADWAY TRANSITIONAL CARE UNIT FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/23/12 Facility Number: 000247 Provider Number: 155356 AIM Number: N/A Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Transitional Care Unit of St. Joseph was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The Transitional Care Unit was fully sprinklered and located on	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	the ninth floor of an eleven story partially sprinklered hospital of Type I (332) construction. The facility has a fire alarm system with smoke detection in the areas open to the corridors and resident rooms. The facility has a capacity of 21 and had a census of 17 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/01/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0020 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation and interview, the facility failed to maintain 1 of 9 elevator enclosures in accordance with NFPA 101, Section 8.2.5.2. Section 8.2.5.2 requires openings through floors, such as hoistways for elevators and stairways, shall be enclosed with two hour fire barriers walls when connecting 4 or more stories. This deficient practice could affect 1 of 2 smoke compartments on the ninth floor. Findings include: Based on an observation with the Administrator, Facilities Manager, Quality Manager and the Director of Nursing on 04/23/12 at 1:14 p.m., a penetration was sealed with expandable foam above the drop down ceiling at elevator # 4. The expandable foam did not maintain the two hour fire rating for the elevator shaft. This was acknowledged by the Facilities	K0020	1. No residents were found to be negatively affected by the deficient practice identified. The penetration was properly sealed immediately after being discovered. 2. No other residents were found to be negatively affected by the deficient practice. 3. All penetration areas will be inspected and have the foam for appropriate rating. An annual above ceiling rated wall inspection program has been developed as part of the facility preventative maintenance program to identify and correct penetration deficiences4. The inspection program is monitored by the Facilities Manager. The results of the above ceiling rated wall inspection will be reviewed at the Quarterly Quality Assurance Meeting to identify any issues or trends. If any issues are identified, corrective action needed will be determined by the Quality Assurance Committee. 5. The above ceiling rated wall inspection will be completed by 05/18/2012	05/18/2012

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	Manager at the time of observation. 3.1-19(b)			

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K0033 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 Based on observation and interview, the facility failed to ensure 1 of 3 exits from the ninth floor provided a safe path of travel to the outside of the building. LSC 101, Section 8.2.5 requires compliance with Section 7.1.3.2.1. which requires openings in the separation shall be protected by fire door assemblies. NFPA 80, Standard for Fire Doors and Windows, Section 2-1.4.1 requires self closing doors shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient practice affects any resident evacuated through stairwell #2. Findings include: Based on an observation with the Administrator, Facilities Manager, Quality Manager and the Director of Nursing on 04/23/12 at 1:48	K0033	1. No residents were negatively affected by the deficient practice. The door was repaired immediately after being discovered. 2. No other residents were negatively affected by the deficient practice. All exit pathways from TCU were inspected and were found to latch into the frame appropriately. 3. A comprehensive quarterly door inspection program was in effect at the time of the survey. The deficiency would have been discovered during the next inspection cycle and repaired at that time. Monthly audit X 3 will be done by the Facility Manager/Designee to ensure that the doors on all exit pathways from TCU latch into the frame. 4. The Facility Manager monitors the quarterly inspection results at the completion of the inspection to verify compliance. The results of these quarterly inspection will be reviewed at the Quarterly Quality Assurance Meeting to identify any issues or trends. If any issues are identified, corrective action needed will be determined by the Quality Assurance Committee. 5. The	05/10/2012

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	p.m., the doors to the elevator # 5 lobby on the ground floor of the facility failed to latch into the frame. The doors were in the two hour separation exit access discharge for stairwell # 2 when evacuating from the ninth floor. This was acknowledged by the Facilities Manager at the time of observation. 3.1-19(b)		quarterly inspection program is currently in effect.	

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 1 of 3 stairwells in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 5-13.3.2 states in noncombustible stair shafts with noncombustible stairs, sprinklers shall be installed at the top of the shaft and under the first landing above the bottom of the shaft. Exception: Sprinklers shall be installed beneath landings or stairways where the area beneath is used for storage. This deficient practice could affect any resident	K0056	1. No residents were negatively affected by the deficient practice. A sprinkler head will be installed at the top level of the stairwell # 2 shaft by 05/18/2012. Stairwell # 2 currently has sprinkler coverage under the first landing at the bottom of the shaft. 2. No other residents were negatively affected by the deficient practice. The other stairwell was checked and appropriate sprinkler heads are in place. 3. Annual sprinkler head inspections will be completed by a qualified contractor. 4. The Facilities Manager will review inspection results for compliance and initiate corrective measures for any deficiences. The results of the inspection will be reviewed at the Quarterly Quality Assurance Meeting to identify any issues or trends. If any issues are identified, corrective action needed will be determined by the	05/18/2012

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	evacuated through stairwell # 2. Findings include: Based on an observation with the Administrator, Facilities Manager, Quality Manager and the Director of Nursing on 04/23/12 from 1:09 p.m. to 2:01 p.m., stairwell # 2 lacked sprinkler coverage at the top and the bottom of the stairwell. Based on an interview with the Facilities Manager at the time of observation, stairwell # 2 did not have sprinkler protection. 3.1-19(b)		Quality Assurance Committee. 5. The changes will be completed by 05/18/2012	

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K0074 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 Based on observation and interview, the facility failed to ensure window curtains in 4 of 12 resident rooms were flame retardant. This deficient practice could 3 of 17 residents. Findings include: Based on observations with the Administrator, Facilities Manager, Qualify Manager and the Director of Nursing on 04/23/12 from 1:31 p.m. to 2:01 p.m., the window coverings in resident rooms 907, 908, 910 and 919	K0074	1. No residents were negatively affected by the deficient practice identified. The curtains from 907, 908, 910 and 919 have been removed and disposed from the hospital2. No other residents were negatively affected by the deficient practice identified. All curtains that did not meet NFPA code have been removed and disposed from the building. 3. Current Hospital Policy LS.02.01.30A requires all new furnishings to be approved by the Director of Facilities Management for NFPA code compliance before purchasing. The curtains in question were purchased in 19924. The corrective action was observed by Administrative Director of Support Services. The	05/10/2012

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	lacked attached documentation confirming they were inherently flame retardant. Based on interview with the Facilities Manager at 2:01 p.m. on 04/23/12, there was no documentation regarding flame retardancy for these window coverings available for review. 3.1-19(b)		new replacement curtains have been reviewed for compliance with NFPA code and approved by the Administrative Director of Support Services. Quarterly audit X 2 will be done by the Facility Manager/Designee to ensure that all curtains and drapes on TCU meet the NFPA code. 5. The results of these quarterly audits will be reviewed at the Quarterly Quality Assurance Meeting to identify any issues or trends. If any issues are identified, corrective action needed will be determined by the Quality Assurance Committee.	